



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.healthplan.memorialhermann.org](http://www.healthplan.memorialhermann.org) or by calling 1-888-594-0671.

| Important Questions                                       | Answers   | Why this Matters:   |
|---|---|---|
| What is the overall <u>deductible</u> ?                   | Participating Provider –<br><b>\$1,500</b> Individual / <b>\$3,000</b> Family; Does not apply to penalties, preventive, Generic, Preferred brand, Non Preferred brand or Specialty prescription drugs<br>Non-Participating Provider – <b>\$3,000</b> Individual / <b>\$6,000</b> Family | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .   |
| Are there other <u>deductibles</u> for specific services? | No.   | You don't have to meet deductibles for specific services, but see the chart starting on page two for other costs for services this plan covers.   |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes.<br>Participating Provider –<br><b>\$5,000</b> Individual / <b>\$10,000</b> Family; Non-Participating Provider - <b>\$10,000</b> Individual / <b>\$20,000</b> Family  | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| What is not included in the <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, utilization review penalties and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Is there an overall annual limit on what the plan pays?   | No.   | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://healthplan.memorialhermann.org/brokers/resource-center/">http://healthplan.memorialhermann.org/brokers/resource-center/</a> or call 1-888-594-0671 for a list of participating providers.  | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?         | No. You don't need a referral to see a specialist.  | You can see the <u>specialist</u> you choose without permission from this plan.   |
| Are there services this plan doesn't cover?               | Yes.  | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .   |

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

| Common Medical Event   | Services You May Need                            | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions   |
|--|--|---|---|--|
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$25/visit                                    | 50% coinsurance, after deductible                 | Participating Provider deductible waived   |
|  | Specialist visit                                 | \$50/visit                                    | 50% coinsurance, after deductible                 | Participating Provider deductible waived   |
|  | Other practitioner office visit                  | \$50/visit                                    | 50% coinsurance, after deductible                 | Participating Provider deductible waived<br>Physical/Occupational Therapy & Chiropractic limited to 20 visits combined per year; 1 visit per day<br>Acupuncture limited to 20 visits per year; 1 visit per day   |
|  | Preventive care/ screening/immunizations         | No charge                                     | 50% coinsurance, after deductible                 | Participating Provider deductible waived   |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | Lab - \$25/visit<br>X-Ray - \$50/visit        | 50% coinsurance, after deductible                 | Participating Provider deductible waived<br>Prior authorization required for Genetic Testing;<br>Non-compliance may result in a service not being covered. No charge, Participating Provider deductible waived in Participating physician’s office with office visit |
|  | Imaging (CT/PET scans MRIs)                      | 20% coinsurance, after deductible             | 50% coinsurance, after deductible                 | Prior authorization required;<br>Non-compliance may result in a service not being covered  |

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| Common Medical Event  | Services You May Need                          | Your Cost If You Use a Participating Provider  | Your Cost If You Use a Non-Participating Provider                     | Limitations & Exceptions  |
|---|--|--|---|---|
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://ctr.benefits.com/portal/memberMain?customer=CTRHX">https://ctr.benefits.com/portal/memberMain?customer=CTRHX</a></p> <p>Or 1-877-633-4461</p> | Generic drugs                                  | No charge/prescription (30 day Retail); No charge/prescription (90 day Mail Order)                   | 50%/prescription - (30 day Retail)<br>90 day Mail Order - Not covered | <p>Annual Participating Provider Deductible does NOT apply to Generic, Preferred brand and Non-preferred brand prescription drugs. Participating Provider Prescription Drug copayments/coinsurance apply to the Annual Participating Provider Out-of-Pocket Maximum. Annual Non-Participating Provider Deductible applies to <b>ALL</b> Non-Participating Provider Prescription Drugs; Non-Participating Provider Prescription Drug Coinsurance applies to the Non-Participating Provider Annual Out-of-Pocket Maximum. Prior authorization required for some Drugs; Non-compliance may result in a service not being covered.</p> <p>Prior authorization required for some Specialty Drugs; Non-compliance may result in a service not being covered.<br/>* 30 day supply only</p> |
|   | Preferred brand drugs                          | \$40/prescription (30 day Retail); \$120/prescription (90 day Mail Order)                            | 50%/prescription - (30 day Retail)<br>90 day Mail Order - Not covered |   |
|   | Non-preferred brand drugs                      | \$75/prescription (30 day Retail); \$225/prescription (90 day Mail Order)                            | 50%/prescription - (30 day Retail)<br>90 day Mail Order - Not covered |   |
|   | Specialty drugs*                               | 25%<br>\$200 Maximum per prescription per member (30 day Retail)*<br>90 day Mail Order - Not Covered | 50%/prescription - (30 day Retail)<br>90 day Mail Order - Not covered |   |
| <p><b>If you have outpatient surgery</b></p>  | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance, after deductible  | 50% coinsurance, after deductible                                     | Prior authorization required; Non-compliance may result in a service not being covered  |
|   | Physician/surgeon fees                         | 20% coinsurance, after deductible  | 50% coinsurance, after deductible                                     | —————none—————  |
| <p><b>If you need immediate medical attention</b></p>   | Emergency room services                        | \$300 then 20% coinsurance per visit   | \$300 then 20% coinsurance per visit                                  | Participating Provider deductible waived<br>Copayment waived if admitted  |
|   | Emergency medical transportation               | 20% coinsurance, after deductible per trip   | 20% coinsurance, after deductible per trip                            | —————none—————  |
|   | Urgent care                                    | \$50/visit   | 50% coinsurance, after deductible                                     | Participating Provider deductible waived  |

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# Memorial Hermann Health Insurance Company: Select 1500-80

Coverage Period: 01/01/2017–12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual, Family | Plan Type: PPO

| Common Medical Event   | Services You May Need                        | Your Cost If You Use a Participating Provider   | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions   |
|--|--|---|---|--|
| If you have a hospital stay  | Facility fee (e.g., hospital room)           | 20% coinsurance, after deductible   | 50% coinsurance, after deductible                 | Prior authorization required; Non-compliance may result in a service not being covered   |
|  | Physician/surgeon fee                        | 20% coinsurance, after deductible   | 50% coinsurance, after deductible                 | —————none—————   |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$25/visit - Professional Office Visit;<br>20% coinsurance, after deductible - Outpatient Services                                      | 50% coinsurance, after deductible                 | Participating Provider Deductible waived for Professional Office Visits;<br>Prior authorization required for Outpatient Services; Non-compliance may result in a service not being covered |
|  | Mental/Behavioral health inpatient services  | 20% coinsurance, after deductible   | 50% coinsurance, after deductible                 | Prior authorization required<br>Non-compliance may result in a service not being covered   |
|  | Substance use disorder outpatient services   | \$25/visit - Professional Office Visit;<br>20% coinsurance, after deductible - Outpatient Services                                      | 50% coinsurance, after deductible                 | Participating Provider Deductible waived for Professional Office Visits;<br>Prior authorization required for Outpatient Services; Non-compliance may result in a service not being covered |
|  | Substance use disorder inpatient services    | 20% coinsurance, after deductible   | 50% coinsurance, after deductible                 | Prior authorization required; Non-compliance may result in a service not being covered   |
| If you are pregnant  | Prenatal and postnatal care                  | 20% coinsurance, after deductible   | 50% coinsurance, after deductible                 | Prior authorization required; Non-compliance may result in a service not being covered   |
|  | Delivery and all inpatient services          | 20% coinsurance, after deductible for Physician's Delivery services & 20% coinsurance, after deductible for Inpatient Facility services | 50% coinsurance, after deductible                 | Prior authorization required; Non-compliance may result in a service not being covered   |

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| Common Medical Event  | Services You May Need     | Your Cost If You Use a Participating Provider  | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions   |
|---|---------------------------|--|---|--|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 20% coinsurance, after deductible per visit  | 50% coinsurance, after deductible per visit       | Limited to 60 visits per year; Prior authorization required; Non-compliance may result in a service not being covered          |
|   | Rehabilitation services   | 20% coinsurance, after deductible Inpatient Facility Services and Outpatient Services \$50/visit Other practitioner office visit | 50% coinsurance, after deductible                 | Prior authorization required for Inpatient & ABA Cognitive Therapy; Non-compliance may result in a service not being covered   |
|   | Habilitation services     | 20% coinsurance, after deductible Inpatient Facility Services and Outpatient Services \$50/visit Other practitioner office visit | 50% coinsurance, after deductible                 | Prior authorization required for Inpatient & ABA Cognitive Therapy<br>Non-compliance may result in a service not being covered |
|   | Skilled nursing care      | 20% coinsurance, after deductible  | 50% coinsurance, after deductible                 | Limited to 100 days per year; Prior authorization required; Non-compliance may result in a service not being covered           |
|   | Durable medical equipment | 20% coinsurance, after deductible  | 50% coinsurance, after deductible                 | Limited to plan requirements; Prior authorization required; Non-compliance may result in a service not being covered           |
|   | Hospice service           | 20% coinsurance, after deductible  | 50% coinsurance, after deductible                 | Prior authorization required; Non-compliance may result in a service not being covered   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$25/visit - Primary Care Physician<br>\$50/visit - Specialist   | 50% coinsurance, after deductible                 | Participating Provider deductible waived<br>1 exam per year for ages 0-19  |
|   | Glasses                   | Not covered  | Not covered                                       | —————none—————   |
|   | Dental check-up           | Not covered  | Not covered                                       | —————none—————   |

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**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Dental care (Adult)
- Long-term care
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care (20 visits per year combined with PT/OT)
- Cosmetic surgery (reconstructive surgery for birth defects, injuries, tumors or infection)
- Hearing aids (1 pair every 36 months)
- Acupuncture (20 visits per year)
- Routine foot care (for an illness such as diabetes or a circulatory disorder of the lower extremities)

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**Your Rights to Continue Coverage:** If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-594-0671. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Memorial Hermann Health Insurance Company Customer Service at 1-888-594-0671.

Texas Department of Insurance  
PO Box 149104  
Austin, TX 78714-9104  
Toll Free Number: 1-800-252-3439  
Fax: 1-512-475-1771  
Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)  
Website: <http://www.tdi.texas.gov>

U. S. Department of Labor  
Employee Benefits Security Administration  
Toll Free Number: 1-866-444-3272  
Website: <http://www.dol.gov/ebsa/healthreform>

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### **Language Access Services:**

Para obtener asistencia en Spanish (Español), llame al 1-888-594-0671.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$3,940
- **Patient pays:** \$3,600

**Sample care costs:**

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

**Patient pays:**

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$200          |
| Coinsurance          | \$800          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$3,600</b> |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-252-7680.

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,500
- **Patient pays:** \$1,900

**Sample care costs:**

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

**Patient pays:**

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Copays               | \$200          |
| Coinsurance          | \$100          |
| Limits or exclusions | \$100          |
| <b>Total</b>         | <b>\$1,900</b> |

**Questions:** Call 1-888-594-0761 or visit us at [www.healthplan.memorialhermann.org](http://www.healthplan.memorialhermann.org)

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your

providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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